Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8305	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTH OF PORTLAND REHAB &	215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments The licensure survey and complaint investigation #43320 was completed on 2/22/18 at Signature Healthcare of Portland. No deficiencies were cited related to the licensure survey or complaint investigation #43320 under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Casey Malone
TITLE: Administrator
(X6) DATE: 3/12/18

STATE FORM 6899 PX4511 If continuation sheet 1 of 1

RECEIVED MAR 15 2018